KELLY & ASSOCIATES INSURANCE GROUP, INC.

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EXISTING MEMBER TERMINATION / CHANGE FORM

Please print clearly in CAPITAL letters **Please fill in the circles completely** ●

1 GENERAL INFORMATION

Company Name | KELLY Company ID#

Last Name | First Name | MI | Title (Jr., III, etc.)

Social Security# | Date of Birth (MM-DD-YY) | Employer Phone#

2 EMPLOYEE TERMINATION OF COVERAGE

○ Terminate **ALL** Active Lines of Coverage ○ Health ○ Vision ○ Vol. Life ○ Vol. Sp. Life ○ STD ○ LTD ○ Suppl. Life/AD&D ○ Dental ○ Life/AD&D ○ Vol. AD&D ○ Vol. Dep. Life ○ Vol. STD ○ Vol. LTD

Reason for Termination: ○ Death of Employee ○ Loss of Dependent Status ○ Non-Payment of COBRA Premium ○ Employment Status Change ○ Enrollment in Medicare ○ Dropping Coverage Voluntarily ○ Gain of Other Coverage ○ End of Employment ○ Reduction in Hours ○ Court Ordered Cancellation ○ Not Eligible ○ Other: _____

Qualifying Event Date: / /

Coverage Term Date: / /

3 CHANGE IN CURRENT COVERAGE LEVEL

MEDICAL ONLY		DENTAL ONLY		VISION ONLY		ALL LINES		OTHER Plan _____	
FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
○ Employee Only	○	○ Employee Only	○	○ Employee Only	○	○ Employee Only	○	○ Employee Only	○
○ Employee & 1 Child	○	○ Employee & 1 Child	○	○ Employee & 1 Child	○	○ Employee & 1 Child	○	○ Employee & 1 Child	○
○ Employee & Spouse	○	○ Employee & Spouse	○	○ Employee & Spouse	○	○ Employee & Spouse	○	○ Employee & Spouse	○
○ Family	○	○ Family	○	○ Family	○	○ Family	○	○ Family	○

Qualifying Event : ○ Marriage ○ Newborn / Adoption ○ Loss of Coverage **Qualifying Event Date:** / / **Requested Date of Change:** / /

Last, Full First, M.I.	Social Security #	Birth Date	Sex (M/F)	F/T Student (Y/N)*	Disabled (Y/N)	*POS or HMO only:* Line 1: PCP Info; Line 2: OB/GYN Info — Physician Name	Physician #	Existing Patient (Y/N)
Sp								
Chd								
Chd								
Chd								

*If full time student, please submit proper form, or appropriate verification of student status (e.g. class schedule, statement from Registrar's office, cancelled check)

Participating Dentist / Provider Code / Dental Office #: Existing Patient: ○ Y ○ N

Are you or any of your dependents eligible for Medicare? If Yes: Effective Date (Part A) / / Effective Date (Part B) / /

4 MISCELLANEOUS CHANGES

Name Change : From: _____ To: _____

Address Change: From: _____ To: _____

Telephone Number Change: From: ( ) _____ To: ( ) _____

Salary Change: From: $ _____ To: $ _____ Effective Date of Change: / /

Provider Change: ○ PCP ○ OB/GYN ○ DENTIST Change for all members?: ○ Y ○ N If no, list member name: _____

From: _____ # _____ To: _____ # _____ Existing Patient: ○ Y ○ N

Medicare: ○ Add ○ Drop

Name: _____ Medicare ID #: _____ Part A: / / Part B: / /

Beneficiary Change- Life Insurance: I am changing my group term Life Insurance beneficiary(s) (Please print full name including middle initial)

Primary To: _____ Relationship: _____

Secondary To: _____ Relationship: _____

5

EMPLOYEE SIGNATURE _____ **DATE** / /

EMPLOYER SIGNATURE / VERIFICATION _____ **DATE** / /

Note: Form invalid without required signatures

2.2.07